

## Opioid Watch

*Nonprofit News from The Opioid Research Institute*

 Menu

# Drug Policy Expert Robert DuPont: The Opioid Crisis is Now About Synthetics and Polydrug Use

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*Robert L. DuPont, MD, at the 2018 National Rx Drug Abuse and Heroin Summit in Atlanta in April.*

## QUICK TAKEAWAY:

- Psychiatrist Robert L. DuPont, MD, has been campaigning against opioid addiction for 50 years.

- In a new Q&A, he says that the opioid crisis, “the defining epidemic of the 21st Century,” needs a “new narrative.”
- “What’s killing these people is not just opioids. It’s opioids in combination with other drugs of abuse.”
- “The global illegal market is switching from agricultural products to purely synthetic drugs.”
- “So illegal drug users … are able to buy more drugs, at higher potency, and lower prices, with more convenient delivery, than ever before.”
- “We need to end the war between the treatment modalities.”

*By Roger Parloff (<mailto:rhp@opioidinstitute.org>)*

*Psychiatrist Robert L. DuPont, MD, has been campaigning against opioid addiction for half a century.*

*In the interview below, conducted with **Opioid Watch** late last month, DuPont explains why he believes today’s opioid crisis—“the defining epidemic of the 21<sup>st</sup> Century”—needs a “new narrative.”*

*He focuses in particular on the problem of polydrug use and the menace posed by synthetic opioids, like fentanyl, flooding in from illicit labs abroad.*

*“Illegal drug users,” he says, “are able to buy more drugs, at higher potency, and lower prices, with more convenient delivery, than ever before.”*

*He also calls for an end to “the war between the treatment modalities,” and wants to see more effort devoted to prevention and “sustainable recovery.”*

*DuPont’s perspectives matter, since few authorities have ever dedicated more hours to grappling with the challenges of opioid addiction than he has.*

*After finishing his psychiatric training at Harvard Medical School and the National Institutes of Health in 1968, DuPont created a heroin addiction treatment program, the District of Columbia’s Narcotics Treatment Administration, which treated 15,000 heroin addicts between 1970 and 1973. In 1973 he became the first director of the National Institute of Drug Abuse (1973-1978) while, at the same time, serving as the White House Drug Chief under Presidents Richard Nixon and Gerald Ford (1973-1977). In 1978 he founded the Institute for Behavior and Health, a non-profit drug policy think tank, which he continues to lead. Since 1980 he has been Clinical*

*Professor of Psychiatry at the Georgetown University School of Medicine. A Distinguished Fellow of the American Society of Addiction Medicine, he has published more than 400 articles and 15 books and monographs on health-related issues.*

*The following is an edited transcript.*

*Opioid Watch: You've said that we need a "new narrative" for the opioid crisis. What do you mean by that?*

*DuPont: Let me say first that the current crisis is the defining epidemic of the 21<sup>st</sup> Century. Historic, massive, gravely serious. It merits all the attention it's getting.*

I started combating opioid addiction when I started my career exactly 50 years ago, in the summer of 1968, when the nation's capital was in the midst of a heroin epidemic.

With that background, here's the issue. The current narrative defines today's problem as springing from overprescription of opioid medicines for chronic pain. That started in the late 1990s and it's only in recent years begun to taper off. It flooded communities with opioids, and made them widely available through medical practice for the first time ever.

It also stranded millions of Americans on opioids for chronic pain, when the current thinking is that this is not an effective treatment for chronic pain. And that's a problem also.

But the reasons I say we need a new narrative are threefold.

First, the opioid problem isn't just about opioids. And to focus just on the opioids misses what the overdose problem is.

Look at the people dying of overdoses and ask: Who are these people? The best data on that come from the Florida Drug-Related Outcomes Surveillance and Tracking System (<https://frost.med.ufl.edu/>) where they looked at toxicology reports for overdose deaths and found that 95 percent of opioid overdoses involved other drugs as well [*see "polysubstance use" on that database, constantly updated*]. The average number of additional drugs was two to four, with as many as 11 drugs present the time of death.

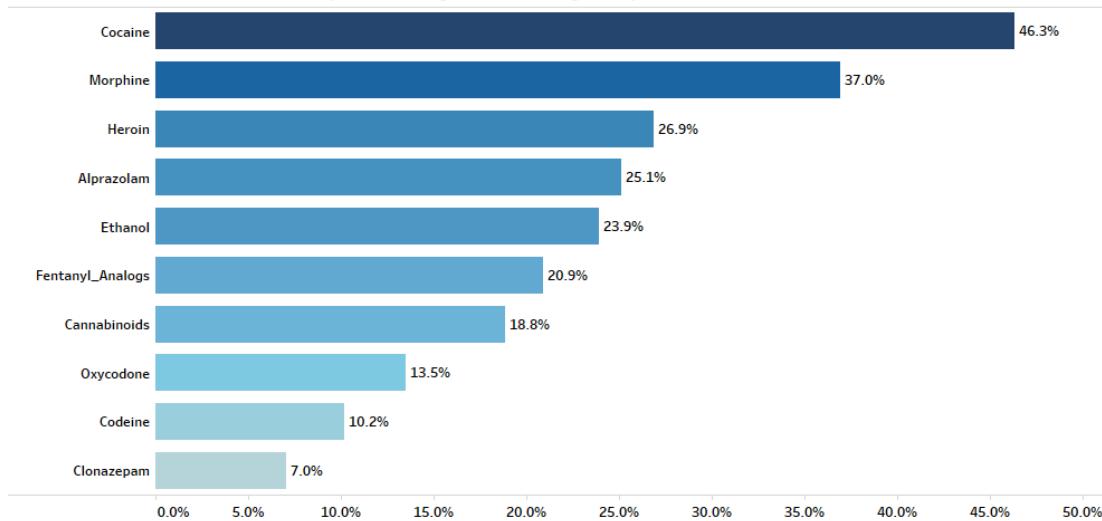
Drug  
Fentanyl

Year  
2016

#### Deaths with Fentanyl in 2016

Only	In Combination with Other Drugs	Total	Present		Grand Total
			Only	In Combination with Other Drugs	
110	1,281	1,391	41	213	254
					1,645

#### Top 10 Co-occurring Substances among Fentanyl-Caused Deaths in 2016



Data: Florida Drug-Related Outcomes Surveillance and Tracking System (FROST) <https://frost.med.ufl.edu> (<https://frost.med.ufl.edu>)

What's killing these people is not just opioids. It's opioids in combination with other drugs of abuse.

We don't have an adequate scientific appreciation for the reason these people are using multiple drugs. The answer to me is that they are doing an experiment in brain biology. They have learned from the experience of using multiple drugs that they get a feeling that is better for them than just using more of a single drug. That "boosting" effect has not been studied and it needs to be. The addicts are way ahead of brain scientists on this.

The key new idea is that these overdose victims are using more than just opioids. That means that we have to understand the problem in a bigger frame than just opioids.

## Medical Patients and Addicted People Use Opioids Differently

My second concern is that the current narrative lacks an understanding of how medical patients use opioids, and how different that is from how addicted people use opioids.

When people are taking an opioid for pain, they take it as the doctor prescribes it. They take it orally, in the dose the doctor prescribes, and they take it for the indication. They don't add other drugs. They don't add alcohol. And they don't take it by non-oral routes of administration. They don't lie to their doctors and they do not doctor shop.

Now addicts do all those things. So their behavior is clearly and dramatically different.

The current narrative would have us believe that people who start with the opioids migrate to the illegal market in some sort of casual way. They find difficulty getting the prescription opioids, so they go to the illegal market and find heroin and fentanyl and other drugs. Then they migrate to IV opioid and other drug use.

*You don't feel there is crossover?*

Oh, absolutely, but the crossover is not natural or casual. And it's not uncommon. It is the difference between medical use of opioids and addictive use, and that difference in behavior is huge and unmistakable. That difference is also now widely ignored or overlooked in the standard opioid narrative. It's a particular group of medical patients who migrate to addictive opioid use.

If you felt stranded on an opioid and your doctor said, "Roger, I'm not going to give you any more opioids," would you put a needle in your vein and use heroin? Medical patients I see would find another doctor.

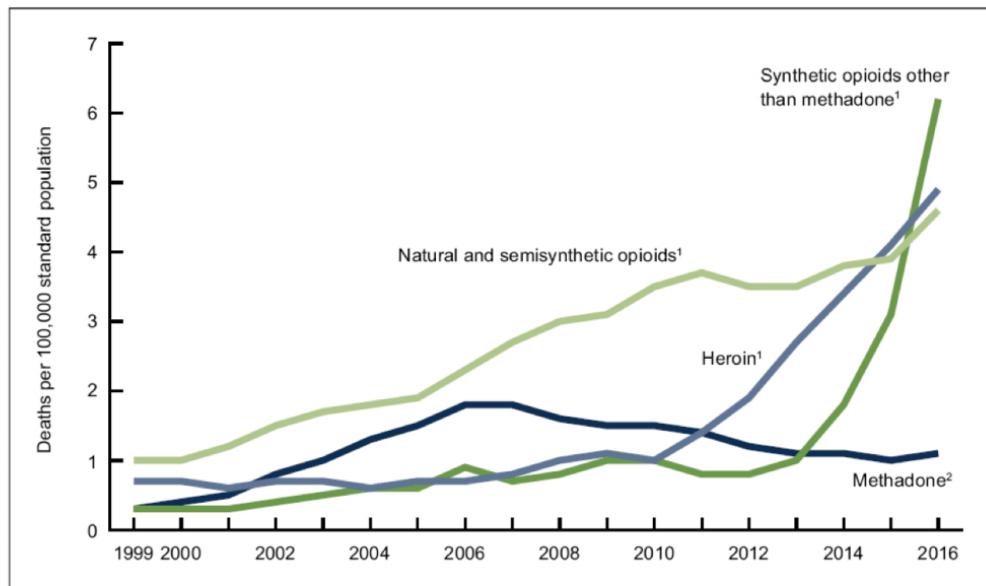
The people who are dying of overdoses mostly go down the addiction road because they like the experience—like it so much they don't want to tell their doctors about how much they like it. They don't want the doctor to take the drug away and they do not want to take the drug the way it's prescribed. They want to take it the way it produces maximum brain reward.

## **The Global Illegal Market Is Switching to Purely Synthetic Drugs**

There's a third point missing from the current narrative. As important as the problem of overprescribing of pain medicine is – and it is very important – the future of the opioid addiction and overdose death problem will not be driven by prescribed opioids. It is being and will continue to be driven by the growing sophistication of the purely illegal drug market which increasingly focuses on the purely synthetic opioids, like fentanyl, and other synthetic drugs.

You can see it in the graphs from the [US Centers for Disease Control and Prevention] on which drugs people are taking when they overdose.

### Age-adjusted drug overdose death rates, by opioid category: United States, 1999–2016



<sup>1</sup>Significant increasing trend from 1999 to 2016 with different rates of change over time,  $p < 0.05$ .

<sup>2</sup>Significant increasing trend from 1999 to 2006, then decreasing trend from 2006 to 2016,  $p < 0.05$ .

NOTES: Deaths are classified using the *International Classification of Diseases, Tenth Revision*. Drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Drug overdose deaths involving selected drug categories are identified by specific multiple-cause-of-death codes: heroin, T40.1; natural and semisynthetic opioids, T40.2; methadone, T40.3; and synthetic opioids other than methadone, T40.4. Deaths involving more than one opioid category (e.g., a death involving both methadone and a natural or semisynthetic opioid) are counted in both categories. The percentage of drug overdose deaths that identified the specific drugs involved varied by year, with ranges of 75%–79% from 1999 to 2013, and 81%–85% from 2014 to 2016. Access data table for Figure 4 at: [https://www.cdc.gov/nchs/data/databriefs/db294\\_table.pdf#](https://www.cdc.gov/nchs/data/databriefs/db294_table.pdf#).

SOURCE: NCHS, National Vital Statistics System, Mortality.

National Center for Health Statistics Data Brief, 294, December 2017.

<https://www.cdc.gov/nchs/products/databriefs/db294.htm>

(<https://www.cdc.gov/nchs/products/databriefs/db294.htm>).

It used to be that the illegal market worked with drugs that were based on agricultural products. Cocaine from a coca leaf. Heroin from the opium poppy.

Now the global illegal market is switching from agricultural products to purely synthetic drugs.

That shift changes the whole dynamic of the epidemic. They've got mobile labs. It used to be there were just a handful of drugs. Now it's literally hundreds. Hundreds of new synthetic drugs are introduced into this market every year. (<https://www.unodc.org/LSS/Page/NPS>) [Opioid Watch has written about the challenges of detecting and prosecuting the flood of new fentanyl analogs here (<https://opioidinstitute.org/2018/04/13/algorithmic-breakthrough-in-the-fight-against-illicit-opioid-trafficking/>).]

So illegal drug users—including, but not limited to opioid users—are able to buy more drugs, at higher potency, and lower prices, with more convenient delivery, than ever before.

That's the reality. I'm all in favor of limiting prescribed opioids. That's a useful thing to do. But that's not where the epidemic is now and where it is headed.

*So in such a world, what do we do?*

We've got to define the drug epidemic as not just opioids and see it as a global problem. The US needs to collaborate with other nations in the world that are dealing with it. There is nothing unique about America in terms of vulnerability to drugs. It is a human vulnerability. The potential for increases in

death and addiction is very great all over the world.

*Do you think China could be doing more than it is doing?*

Yes, absolutely. And Mexico, also. But remember that drug traffickers can go to any country. They're not stuck in China or Mexico.

We need to get a lot smarter about prevention, treatment, and law enforcement. Just doing more of what we're doing now is not going to cut it.

*What can we do about prevention?*

Illegal drugs are being used not primarily by people who've been on opioids for pain. It's people who have used lots of other drugs before—90 percent starting in adolescence.

The most important thing we need to do is help kids grow up drug-free. Because priming the brain for drug responses in the teenage years is a very big factor in adult drug vulnerability to addiction.

*What's the evidence of that?*

That the people using the drugs generally started very early. The earlier they start in their teenage years, the greater their chances of addiction. The unique vulnerability of the adolescent brain to drugs of abuse is very striking.

It's like with cigarettes. If a kid doesn't start by age 21, the chance he'll start after that age is very low. The same is true for other drugs, too.

At the end of the day, we're going to have to do a lot about the demand side. We're going to have to make it a lot more unattractive to Americans to use the drugs. We're going to have to intervene a lot more aggressively when people do use drugs.

*Say someone overdoses, goes to the ER, is stabilized, but then doesn't want treatment, What do we do?*

What's happening with the addictions is a hijacking of the brain. When you're talking to somebody who's using, you're talking to the drug, not the person.

The first order of business is to mobilize the drug users' families—especially families of addicted people who keep using drugs and failing at treatment. We need to empower families to be a lot more active about not only getting people into treatment but also keeping them in treatment and insisting that they get to stable recovery.

They need to be able to say: This is a requirement in this family. Sometimes that will mean drug users will have to be drug tested to ensure that they do not use.

## **The Problem With Medication-Assisted Treatments**

*Let's talk about treatment, then. How do we improve it?*

The standard addiction treatment has become medication-assisted treatment, with three different drugs: methadone, naltrexone, and buprenorphine. That's a good thing. [Medication-assisted treatment, or MAT, anticipates a long-term—often lifetime—regimen of medication, supplemented with therapy, counseling, and/or support groups. Though methadone and buprenorphine are themselves opioids, they can be administered without inducing euphoria and without injection, permitting resumption of a normal life. Naltrexone is not an opioid.]

I was involved with methadone at its creation. We started a major methadone program in Washington, DC, in 1970. I'm very positive about medication-assisted treatment.

But there's a problem. The typical patient taking buprenorphine and naltrexone —about half of them [drop out of treatment within] three to six months. For methadone, half are gone within six to nine months. That's a very big problem. The programs that do not use medicines have even shorter stays.

All the treatments, with or without medication, need to be assessed on their ability to produce sustained recovery which means no use of alcohol or other drugs, and character development. Usually that means active participation in recovery communities, like Alcoholics Anonymous and Narcotics Anonymous and other similar programs for many years.

The treatment of substance use disorders—not just opioids but drugs in general—needs to be integrated within health care, and the primary care physician needs to identify the people who are addicted and manage that disorder like any other medical disorder. And that means testing to see whether the patients are using, just like the physicians test for blood pressure and diabetes.

The problem today is that the addiction treatment is siloed and short, and the primary care physicians are not involved in the long-term management of that patient's care.

About ten years ago, Tom McLellan ([https://en.wikipedia.org/wiki/A.\\_Thomas\\_McLellan](https://en.wikipedia.org/wiki/A._Thomas_McLellan)) [Deputy Director of the Office of National Drug Control Policy from 2009-12] and I did a national study (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2590904/>) of physicians who were themselves addicted. These physicians were under the care management of their state physician health program (PHP). About half the doctors in the study had an alcohol problem, a third had an opioid problem—including some intravenous users—and the rest had other substance use disorders.

What we found was an incredible success rate—80-plus percent—after 5 years. Stunningly good results. Seventy-eight percent (<https://www.ncbi.nlm.nih.gov/pubmed/19161896>) of these physicians—who were subject to random testing typically for 5 years—did not have a single missed or positive test for alcohol or other drugs. [*Long-term outcomes for physicians with opioid use disorder* (<https://www.ncbi.nlm.nih.gov/pubmed/26971079>) were as good as for those with alcohol use disorder.]

The formal addiction treatment they had was typically 30 days of residential care. There was no use of methadone or buprenorphine, and little use of naltrexone (which was mostly for alcoholic physicians). But they had a lot of support. They were required to go to meetings like AA and NA for the 5 years, typically several times a week.

They also had very close monitoring, with random drug tests. If they refused to take one, or failed it, they risked losing their licenses. There were great consequences for returning to the use of alcohol or other drugs.

The lesson I learned from this study is that our country needs to do a lot better job—in medication-assisted treatment *or* non-medication-assisted treatment—of extending the period of disease management for a period like five years. We need to monitor drug and alcohol use over that time. And

we need to use community support, like AA/NA, for long periods.

## The War In Addiction Treatment

*To be clear, for treatment of opioid addiction you do favor, don't you—or do you—medication-assisted treatment over just a 12-step program without medication?*

I define this as the war in addiction treatment

(<https://www.asam.org/resources/publications/magazine/read/article/2016/08/05/seizing-the-moment-to-improve-addiction-treatment>). The war is between the medication-assisted treatment and the “drug-free” treatment.

The recovery movement is dominated by self-help groups, like Alcoholics Anonymous and Narcotics Anonymous. One of the things I'm most proud to be an American about is the invention in 1935 in Akron, Ohio, of AA, which is an absolutely amazing program. It has tremendous applicability not just to alcohol, but to opioids and other drug use.

All our diagnoses are substance specific. It's opioid use disorder, alcohol use disorder, stimulant use disorder. But the reality of the addiction is that it's multiple drugs, not just one. And in the 12-step programs there's clarity that it's not just this one drug. Recovery includes not using any of them.

About four years ago, the leading model for self-help recovery, the Hazelden (<https://www.hazelden.org/>) program in Minnesota, integrated buprenorphine and naltrexone into their program for treatment of opioid addiction.

The drug-free programs need to offer medications as options. At the same time, medication-assisted treatments need to integrate AA and NA, and other community support, into their programs. And both programs that use and do not use medications need to be judged on their abilities to produce lasting recovery

We need to, all together, recognize that when a patient is taking buprenorphine or methadone or naltrexone as it's prescribed, that's a medicine and not a drug. Use of medications as directed and no use of alcohol or other drugs of abuse needs to be defined by everyone as fully compatible with recovery.

We need to end the war between the treatment modalities for the sake of our patients and to deal with the deadly drug and overdose epidemic our nation faces today. ■